How are behavioral health consult appointments/medical team consultations documented in the medical record?

A cornerstone of integrated care is that documentation of physical and behavioral healthcare resides in one medical record. Many PCBH programs have adopted the Subjective, Objective, Assessment, Plan (SOAP) note format because it mirrors the documentation format used in primary care. Good SOAP notes reflect integrative thinking. This means not just reporting details but combining them into a coherent whole that frames the information in a functional way. This is done through connecting symptoms, severity and events. The BHC is relating the data the patient gave (Subjective) and combining it with objective data (Objective), integrating these into a coherent understanding of what is keeping this patient from functioning (Assessment) and producing a plan based on these factors (Plan). The SOAP note is brief and directs other team members to the action plan agreed upon with the person receiving care. SOAP notes are also written with consideration for inclusion of only the relevant data related to that person’s ongoing care, omitting irrelevant or unnecessary data that might be included in broader specialty mental health records. Generally, the following elements are present in the behavioral health consultant SOAP note.

**Subjective:**
- Referred by
- Reason for Referral
- Chief Complaint Today
- Presenting Symptoms
- Severity of Symptoms
- Chronicity of Symptoms
- Prior Treatment History
- Mitigating Factors

**Objective:**
- Orientation (x3, cognition, speech)
- Appearance
- Affect
- Suicidal/Homicidal ideation
- Substance Abuse
- Medications (psychotropic meds, adherence)
- Test results of any mental health measures used

**Assessment:**
- Provisional Diagnosis
- Motivation and Stage of Change
- Key Area for Intervention
- Clinician Assessment of Progress or lack thereof on follow-up notes

**Plan:**
- Recommendations to the PCP
- Follow-Up Date (if applicable)
